FOR OHF USE

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0027680

Facility Name: Sheridan Health Care Center

Address: 2534 Elim Avenue (Number) Zion (City) 60099 (Zip Code)

County: Lake

Telephone Number: (847) 746-8435 **Fax #** (847) 746-1744

IDPA ID Number: 363194993001

Date of Initial License for Current Owners: 10/10/82

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Garry S. Chankin, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 11/15/04

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	96	Skilled (SNF)	87	34,713	1
2		Skilled Pediatric (SNF/PED)			2
3	174	Intermediate (ICF)	163	63,167	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	270	TOTALS	250	97,880	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	290		5,850	6,140	8
9	SNF/PED					9
10	ICF	65,515	4,688	1,050	71,253	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	65,805	4,688	6,900	77,393	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.07%

D. How many bed-hold days during this year were paid by Public Aid? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
Meals on Wheels, Adult Day Care

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/1/1982

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/1/1982 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 54 and days of care provided 5,429

Medicare Intermediary AdminaStar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	367,227	76,531	16,347	460,105		460,105		460,105			1
2	Food Purchase		440,476		440,476		440,476	(266)	440,210			2
3	Housekeeping	312,460	77,621		390,081		390,081		390,081			3
4	Laundry	166,756	65,543	771	233,070		233,070		233,070			4
5	Heat and Other Utilities			253,807	253,807		253,807		253,807			5
6	Maintenance	249,020	26,877	95,132	371,029		371,029	(14,809)	356,220			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,095,463	687,048	366,057	2,148,568		2,148,568	(15,075)	2,133,493			8
	B. Health Care and Programs											
9	Medical Director			24,018	24,018		24,018		24,018			9
10	Nursing and Medical Records	3,317,922	183,189	7,161	3,508,272		3,508,272	(1,718)	3,506,554			10
10a	Therapy	73,052	1,641	15,998	90,691		90,691		90,691			10a
11	Activities	151,862	17,925	845	170,632		170,632		170,632			11
12	Social Services	440,075	2,947	5,413	448,435		448,435		448,435			12
13	Nurse Aide Training			5,957	5,957		5,957		5,957			13
14	Program Transportation			6,131	6,131		6,131		6,131			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,982,911	205,702	65,523	4,254,136		4,254,136	(1,718)	4,252,418			16
	C. General Administration											
17	Administrative	174,049		265,000	439,049		439,049	(199,290)	239,759			17
18	Directors Fees											18
19	Professional Services			84,748	84,748		84,748		84,748			19
20	Dues, Fees, Subscriptions & Promotions			105,682	105,682		105,682	(61,651)	44,031			20
21	Clerical & General Office Expenses	203,310	6,232	182,829	392,371		392,371	(84,092)	308,279			21
22	Employee Benefits & Payroll Taxes			788,493	788,493		788,493	(1,921)	786,572			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,314	10,314		10,314	(1,060)	9,254			24
25	Other Admin. Staff Transportation			2,238	2,238		2,238	(1,370)	868			25
26	Insurance-Prop.Liab.Malpractice			167,650	167,650		167,650		167,650			26
27	Other (specify):*							4,170	4,170			27
28	**TOTAL General Administration**	377,359	6,232	1,606,954	1,990,545		1,990,545	(345,214)	1,645,331			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,455,733	898,982	2,038,534	8,393,249		8,393,249	(362,007)	8,031,242			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Sheridan Health Care Center #0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			414,673	414,673		414,673	(4,878)	409,795			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			240,739	240,739		240,739	(23,629)	217,110			32
33	Real Estate Taxes			208,759	208,759		208,759		208,759			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			31,808	31,808		31,808		31,808			35
36	Other (specify):*			8,497	8,497		8,497	(8,497)				36
37	**TOTAL Ownership**			904,476	904,476		904,476	(37,004)	867,472			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		305,683	385,605	691,288		691,288		691,288			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			5,795	5,795		5,795	(5,795)				41
42	Provider Participation Fee			146,820	146,820		146,820		146,820			42
43	Other (specify):*	84,688		4,376	89,064		89,064	(89,064)				43
44	**TOTAL Special Cost Centers**	84,688	305,683	542,596	932,967		932,967	(94,859)	838,108			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,540,421	1,204,665	3,485,606	10,230,692		10,230,692	(493,870)	9,736,822			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$ (48,132)	43	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,924)	30		9
10	Interest and Other Investment Income	(23,629)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(266)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(7,675)	20		20
21	Owner or Key-Man Insurance	(1,921)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(84,092)	21		24
25	Fund Raising, Advertising and Promotional	(34,759)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(14,064)	20		28
29	Other-Attach Schedule	(80,288)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (298,751)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(195,120)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (195,120)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (493,870)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 5A

Sheridan Health Care Center

IDF 0027680

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (5,795)	41	1
2	VA Lab Expense	(488)	10	2
3	VA Physician Expense	(1,230)	10	3
4	Amortization	(8,497)	36	4
5	COPE Dues	(5,003)	20	5
6	Settlement	(1,370)	25	6
7	Marketing Expense	(510)	43	7
8	Bank Charges	(150)	20	8
9	2005 Seminar	(583)	24	9
10	Marketing Seminar	(477)	24	10
11	Marketing Salary	(40,422)	43	11
12	Capitalized R&M	(14,809)	06	12
13	Non-Care Depreciation	(954)	30	13
14				14
15				15
16				16
17				17
18				18
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98				98
99				99
100				100
101	Total	(80,288)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sheridan Health Care Center # 0027680 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(266)											(266)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(14,809)											(14,809)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(15,075)											(15,075)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,718)											(1,718)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(1,718)											(1,718)	16
	C. General Administration													
17	Administrative			(143,694)	7,420	(51,067)	(11,949)						(199,290)	17
18	Directors Fees													18
19	Professional Services													19
20	Fees, Subscriptions & Promotions	(61,651)											(61,651)	20
21	Clerical & General Office Expenses	(84,092)											(84,092)	21
22	Employee Benefits & Payroll Taxes	(1,921)											(1,921)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(1,060)											(1,060)	24
25	Other Admin. Staff Transportation	(1,370)											(1,370)	25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*			3,499		171	500						4,170	27
28	**TOTAL General Administration**	(150,094)		(140,195)	7,420	(50,896)	(11,449)						(345,214)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(166,887)		(140,195)	7,420	(50,896)	(11,449)						(362,007)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sheridan Health Care Center # 0027680 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(4,878)											(4,878)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(23,629)											(23,629)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(8,497)											(8,497)	36
37	**TOTAL Ownership**	(37,004)											(37,004)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops	(5,795)											(5,795)	41
42	Provider Participation Fee													42
43	Other (specify):*	(89,064)											(89,064)	43
44	**TOTAL Special Cost Centers**	(94,859)											(94,859)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(298,751)		(140,195)	7,420	(50,896)	(11,449)						(493,870)	45

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	SALARY - STAN ARON	$	PRO HEALTH CARE, INC.	100.00%	$ 43,086	$ 43,086	15
16	V	27	PAYROLL TAXES				3,499	3,499	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V	17	MNGMNT. FEES - PRO HEALTH	76,780				(76,780)	23
24	V	17	MNGMNT. FEES - PRO HEALTH	110,000				(110,000)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 186,780			$ 46,585	$ * (140,195)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		17	MANAGEMENT FEES	$ 155,000	SHA, LTD.	100.00%	$	$ (155,000)	15
16	V		17	M. FEES - SHABAT & ASSOC.		SHA, LTD.		19,030	19,030	16
17	V		17	M. FEES - FINN CONS.		SHA, LTD.		66,610	66,610	17
18	V		17	M. FEES - PRO HEALTH		SHA, LTD.		76,780	76,780	18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 155,000			$ 162,420	$ * 7,420	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	SALARY - J.FINN	$	FINN CONSULTING, INC.	100.00%	$ 15,543	$ 15,543	15
16	V	27	PAYROLL TAXES		FINN CONSULTING, INC.		171	171	16
17	V								17
18	V	17	MANAGEMENT FEES	66,610	FINN CONSULTING, INC.			(66,610)	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 66,610			$ 15,714	$ * (50,896)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		17	SALARY - RON SHABAT	$	SHABAT & ASSOCIATES	100.00%	$ 7,081	$ 7,081	15
16	V		27	PAYROLL TAXES		SHABAT & ASSOCIATES		500	500	16
17	V									17
18	V		17	MANAGEMENT FEES	19,030	SHABAT & ASSOCIATES			(19,030)	18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 19,030			$ 7,581	$ * (11,449)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Stanton Aron	Partner	Management	16.31%	See Attached	22.00	33.80%	Allocated	$ 43,085	17-7	1
2	Jack Finn	Partner	Mgmt Cons.	9.32%	See Attached	17.00	48.50%	Allocated	15,543	17-7	2
3	Ron Shabat	Partner	Mgmt Cons.	15.04%	See Attached	2.00	5.40%	Allocated	7,081	17-7	3
4	Nanjean Painter	Partner	Management	1.75%	See Attached	40.00	80.00%	Salary	124,374	12-1	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 190,083		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PRO HEALTH CARE, INC. C/O FR&R
Street Address: 111 PFINGSTEN ROAD
City / State / Zip Code: DEERFIELD, IL 60115
Phone Number: ((847)236-1111
Fax Number: ((847)236-1155

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	SALARY - STAN ARON	AVG. HOURS WORKED	51	4	$ 99,880	$ 99,880	22	$ 43,086	1
2	27	PAYROLL TAXES	AVG. HOURS WORKED	51	4	8,112		22	3,499	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 107,992	$ 99,880		$ 46,585	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: SHA, LTD. C/O FR&R
Street Address: 111 PFINGSTEN ROAD
City / State / Zip Code: DEERFIELD, IL 60115
Phone Number: ((847)236-1111
Fax Number: ((847)236-1155

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2	17	Management Fees	Direct		1	162,420			162,420	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 162,420	$		$ 162,420	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: FINN CONSULTING INC.
Street Address: 7141 N. KEDZIE AVE.
City / State / Zip Code: CHICAGO, IL 60645
Phone Number: ((773)764-3466
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	SALARY - J.FINN	AVG. HOURS WORKED	35	2	$ 32,000	$ 32,000	17	15,543	1
2	27	PAYROLL TAXES	AVG. HOURS WORKED	35	2	353		17	171	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 32,353	$ 32,000		$ 15,714	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: SHABAT & ASSOCIATES
Street Address: 7514 N. SKOKIE BLVD.
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: ((847)982-1195
Fax Number: ((847)982-0992

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	SALARY - RON SHABAT	AVG. HOURS WORKED	37	11	131,000	131,000	2	7,081	1
2	27	PAYROLL TAXES	AVG. HOURS WORKED	37	11	9,249		2	500	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 140,249	$ 131,000		$ 7,581	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Manufacturers Bank		X	Mortgage	$46,648.00	9/28/98	$ 4,500,000	$ 2,659,780	9/2008	7.4000	$ 198,335	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Manufacturers Bank		X	Line of Credit	Various	7/10/94	1,700,000	1,485,000	7/10/05	5.0000	42,404	6
7	First Midwest Bank		X	Line of Credit	Various	4/2003	129,500	149,398				7
8	See Supplemental Schedule											8
9	TOTAL Facility Related				$46,648.00		$ 6,329,500	$ 4,294,178			$ 240,739	9
	B. Non-Facility Related*											
10	Interest Income		X								(23,629)	10
11												11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (23,629)	14
15	TOTALS (line 9+line14)						$ 6,329,500	$ 4,294,178			$ 217,110	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 0 Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	215,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	206,759	2
3. Under or (over) accrual (line 2 minus line 1).	$	(8,241)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	217,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	208,759	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	150,301	8
	2000	160,170	9
	2001	188,807	10
	2002	204,829	11
	2003	206,759	12

Accrual = 206,759 x 1.05 = 217,000

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sheridan Health Care Center COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0027680

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-22-301-007	Long Term Care Property	$ 197,793.94	$ 197,793.94
2.	04-22-301-009	Long Term Care Property	$ 8,965.40	$ 8,965.40
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 206,759.34	$ 206,759.34

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sheridan Health Care Center COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0027680

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 83,793 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 4

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Adult Day Care - 760 square feet

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	50,091	1990	$ 28,460	1
2					2
3	TOTALS	50,091		$ 28,460	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	270			1990	$ 5,384,307	$ 170,930		$ 153,837	$ (17,093)	$ 2,294,735	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1980	5,655		20	-		5,655	9
10	Various			1981	13,906		20	-		13,906	10
11	Various			1982	1,171		20	-		1,171	11
12	Various			1983	17,000		20	-		16,819	12
13	Various			1984	36,737		20	-		36,737	13
14	Various			1985	135,882		20	4,773	4,773	135,840	14
15	Various			1986	63,852		20	3,361	3,361	62,178	15
16	Various			1987	60,439		20	3,021	3,021	53,092	16
17	Various			1988	24,257		20	1,212	1,212	20,001	17
18	Various			1989	102,083		20	4,700	4,700	94,316	18
19	Various			1990	84,998		20	4,250	4,250	62,897	19
20	Various			1991	10,496		20	526	526	7,252	20
21	Various			1992	18,109		20	889	889	11,267	21
22	Various			1993	39,981		20	1,999	1,999	23,338	22
23	Various			1994	123,996		20	6,203	6,203	65,633	23
24	Various			1995	157,007		20	7,851	7,851	76,721	24
25	Various			1996	210,423		20	10,523	10,523	88,208	25
26	Various			1997	97,938		20	4,898	4,898	37,185	26
27	Various			1998	76,538		20	3,828	3,828	23,967	27
28	Various			1999	232,757		20	11,332	11,332	60,997	28
29	Various			2000	88,771		20	4,411	4,411	20,638	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)								67
68	Related Party Allocations (Pages 12-REP & 12A-REP)								68
69	Financial Statement Depreciation			133,740			(133,740)		69
70	TOTAL (lines 4 thru 69)		$ 6,986,303	$ 304,670		$ 227,614	$ (77,056)	$ 3,212,553	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,986,303	$ 304,670		$ 227,614	$ (77,056)	$ 3,212,553	1
2	Fire Door & Install	2001	4,000		20	200	200	800	2
3	Door Replacement	2001	5,425		20	271	271	1,062	3
4	Cornices & Valances	2001	2,455		20	123	123	492	4
5	Window Treatment	2001	2,162		20	108	108	423	5
6	Wallcovering	2001	1,782		20	89	89	349	6
7	Wallcovering	2001	2,217		20	111	111	426	7
8	Remodeling	2001	8,000		20	400	400	1,500	8
9	Fire Panel	2001	605		20	30	30	114	9
10	Remodeling	2001	2,780		20	139	139	521	10
11	Fire Insulation	2001	546		20	27	27	100	11
12	Electric Circuit	2001	230		20	12	12	43	12
13	Remodeling/Drywall	2001	3,286		20	164	164	630	13
14	Fire Dampers	2001	9,779		20	489	489	1,793	14
15	Birch Doors	2001	2,616		20	131	131	469	15
16	Floors	2001	1,883		20	94	94	337	16
17	Wallpaper	2001	1,358		20	68	68	244	17
18	Refrigeration Lines	2001	10,203		20	510	510	1,828	18
19	Wooden Planters	2001	200		20	10	10	36	19
20	Refrigeration Lines	2001	10,204		20	510	510	1,828	20
21	Pull Station Protect	2001	1,163		20	58	58	208	21
22	Room Sign	2001	745		20	75	75	262	22
23	Handrail	2001	1,955		20	98	98	343	23
24	Electrical Circuits	2001	2,198		20	110	110	385	24
25	Refrigeration Lines	2001	4,689		20	234	234	820	25
26	Fire Damper	2001	616		20	31	31	109	26
27	Boiler	2001	743		20	37	37	130	27
28	Wallpaper	2001	4,243		20	212	212	707	28
29	Renovations	2001	1,900		20	95	95	309	29
30	Mosaic/Grout	2001	800		20	21	21	66	30
31	Upholsted Cornices	2001	769		20	38	38	125	31
32	Cement	2001	383		20	19	19	60	32
33	Solar Shades	2001	4,028		20	403	403	1,276	33
34	TOTAL (lines 1 thru 33)		$ 7,080,266	$ 304,670		$ 232,531	$ (72,139)	$ 3,230,348	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 7,080,266	$ 304,670		$ 232,531	$ (72,139)	$ 3,230,348	1
2	Roof Insulation	2001	5,950		20	298	298	943	2
3	Handrail/Vinyl Floor	2001	6,519		20	326	326	1,005	3
4	Wallpaper	2001	1,537		20	77	77	237	4
5	Reciprocal Chiiler	2001	4,576		20	229	229	706	5
6	Central Air Blower	2001	1,192		20	60	60	224	6
7	Fire Dampers	2001	9,103		20	455	455	1,706	7
8	Padding	2001	908		20	45	45	155	8
9	Apartment Compactor	2001	9,830		20	492	492	1,680	9
10	Wallpaper	2001	2,905		20	145	145	496	10
11	Drain Work	2001	1,794		20	179	179	553	11
12	Fire Dampers	2001	2,133		20	107	107	329	12
13	Coil Repairs	2001	1,605		20	80	80	247	13
14	Motor	2001	705		20	35	35	109	14
15	Landscaping	2001	925		20	46	46	143	15
16	Compressor Repairs	2001	4,255		20	213	213	656	16
17	Door Edges	2002	4,091		20	409	409	1,227	17
18	Amp Box	2002	802		20	80	80	241	18
19	Shades	2002	10,131		20	1,013	1,013	2,870	19
20	Doors	2002	861		20	86	86	244	20
21	Boiler	2002	7,883		20	657	657	1,861	21
22	Pergo Floor	2002	2,054		20	137	137	377	22
23	Generator	2002	8,200		20	1,171	1,171	3,124	23
24	Flooring	2002	449		20	30	30	80	24
25	Water Heater	2002	7,602		20	634	634	1,689	25
26	Door & Frame	2002	1,651		20	165	165	440	26
27	Compressor	2002	12,526		20	1,789	1,789	4,474	27
28	Medical Office	2002	44,200		20	4,420	4,420	11,050	28
29	Bathroom	2002	1,306		20	87	87	210	29
30	Architect Fee	2002	6,000		20	154	154	346	30
31	Cement Curb	2002	895		20	90	90	201	31
32	Landscaping/Curbs	2002	2,536		20	169	169	380	32
33	Burners	2002	8,395		20	420	420	944	33
34	TOTAL (lines 1 thru 33)		$ 7,253,785	$ 304,670		$ 246,829	$ (57,841)	$ 3,269,295	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 7,253,785	$ 304,670		$ 246,829	$ (57,841)	$ 3,269,295	1
2	Window Treatment	2002	944		20	94	94	275	2
3	Smoke Alarms	2002	792		20	113	113	292	3
4	Window Coverings	2002	3,477		20	348	348	753	4
5	Wallpaper Dining Room	2002	1,447		20			1,447	5
6	Wallpaper Resident Rooms	2002	3,053		20			3,053	6
7	Wallpaper Offices	2002	927		20			927	7
8	Wallpaper Breakrooms	2002	1,252		20			1,252	8
9	Wallpaper Office/Breakroom	2002	1,949		20			1,949	9
10	Painting	2002	4,000		20			4,000	10
11	Painting	2002	4,000		20			4,000	11
12	Wallpaper 3Rd Floor	2002	5,212		20			5,212	12
13	Floor Switch Repairs	2002	575		20	58	58	153	13
14	Heater Repairs	2002	758		20	76	76	196	14
15	Water Heater Repairs	2002	2,228		20	223	223	483	15
16	Pilot Safety Valve Install	2002	2,070		20	207	207	431	16
17	Elevator Repairs	2002	1,104		20	55	55	138	17
18	Elevator Repairs	2002	2,173		20	109	109	226	18
19	Boiler Repairs	2002	1,441		20	120	120	340	19
20	Crash Rail	2003	6,798		20	680	680	1,360	20
21	Handrail	2003	7,633		20	763	763	1,527	21
22	Platform	2003	1,386		20	139	139	277	22
23	Cove Base	2003	515		20	34	34	69	23
24	Carpeting	2003	29,162		20	4,166	4,166	7,638	24
25	Carpeting-Asbestos Removal	2003	1,905		20	272	272	499	25
26	Sprinkler Heads	2003	1,500		20	150	150	275	26
27	Remodel	2003	6,650		20	665	665	1,219	27
28	Electrical Work	2003	5,920		20	592	592	1,085	28
29	Architect-Floor Plan	2003			20				29
30	Ramp Training Set	2003	810		20	81	81	155	30
31	Electronic Key Override	2003	1,718		20	172	172	329	31
32	Office Rehab	2003	104,717		20	10,472	10,472	18,325	32
33	Wallpaper	2003	1,276		20	425	425	1,276	33
34	TOTAL (lines 1 thru 33)		$ 7,461,177	$ 304,670		$ 266,843	$ (37,827)	$ 3,328,456	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 7,461,177	$ 304,670		$ 266,843	$ (37,827)	$ 3,328,456	1
2	Wiring And Termination	2003	3,725		20	373	373	621	2
3	Signs	2003	512		20	51	51	90	3
4	Fire Dampers	2003	854		20	122	122	224	4
5	Alarm Detection System	2003	109,900		20	10,990	10,990	18,317	5
6	Doors	2003	1,269		20	63	63	106	6
7	Office Rehab	2003	12,134		20	1,213	1,213	2,022	7
8	Sprinkler	2003	700		20	47	47	82	8
9	Doors	2003	1,722		20	86	86	144	9
10	Flooring	2003	1,250		20	83	83	139	10
11	Wallpaper	2003	1,174		20	391	391	1,174	11
12	Wallpaper	2003	3,069		20	1,023	1,023	3,069	12
13	Handrail	2003	663		20	33	33	52	13
14	Nursing Station	2003	17,600		20	1,760	1,760	2,933	14
15	Chimney	2003	975		20	65	65	103	15
16	Doors	2003	385		20	26	26	41	16
17	Floors	2003	6,618		20	441	441	699	17
18	John Edward - Doors & Locks	2003	536		20	36	36	57	18
19	Fire Alarm	2003	1,510		20	216	216	324	19
20	Timer	2003	656		20	131	131	197	20
21	Alarm Detection Syst	2003	4,499		20	643	643	857	21
22	Door Frame	2003	1,750		20	88	88	117	22
23	Floor Tiles	2003	11,352		20	757	757	1,198	23
24	Vacuum Pump	2003	7,683		20	512	512	726	24
25	Aluminum Doors	2003	7,951		20	530	530	751	25
26	Roof	2003	34,512		20	3,451	3,451	5,464	26
27	Shades	2003	10,154		20	1,015	1,015	1,523	27
28	Alarm Detection	2003	1,000		20	143	143	179	28
29	Carpeting	2003	7,870		20	1,146	1,146	1,337	29
30	Blinds	2003	1,918		20	192	192	208	30
31	Fire Doors	2003	6,150		20	879	879	1,025	31
32	Boiler	2003	4,749		20	396	396	462	32
33	Elevator Alarm	2003	1,473		20	74	74	86	33
34	TOTAL (lines 1 thru 33)		$ 7,727,490	$ 304,670		$ 293,819	$ (10,851)	$ 3,372,783	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 7,727,490	$ 304,670		$ 293,819	$ (10,851)	$ 3,372,783	1
2	Tile	2003	1,053		20	70	70	94	2
3	Tile	2003	1,555		20	104	104	121	3
4	Tile	2003	3,623		20	242	242	322	4
5	Window Treatments	2003	3,199		20	320	320	373	5
6	Boiler Repairs	2003	2,007		20	100	100	117	6
7	Boiler Repairs	2003	3,687		20	184	184	230	7
8	Roof Repairs	2003	578		20	29	29	48	8
9	Steam Table Repairs	2003	2,582		20	129	129	172	9
10	Building Façade	2003	23,626		20	2,363	2,363	3,741	10
11	Auto Door Opener*	2004	2,935		20	294	294	294	11
12	Electrical Wiring*	2004	1,015		20	102	102	102	12
13	Awning*	2004	16,574		20	1,243	1,243	1,243	13
14	Penthouse Rennovations*	2004	9,424		20	628	628	628	14
15	Fire Alarm Repairs*	2004	91,390		20	8,704	8,704	8,704	15
16	Roof Repairs*	2004	19,836		20	1,157	1,157	1,157	16
17	Boiler	2004	100,000		20	4,861	4,861	4,861	17
18	Wallpaper	2004	1,101		20	551	551	551	18
19	Pump	2004	5,700		20	95	95	95	19
20	Pipe Work	2004	7,680		20	256	256	256	20
21	Elevator Motor	2004	2,000		20	95	95	95	21
22	Automatic Doors	2004	4,915		20	164	164	164	22
23	Kitchen Doors	2004	727		20	4	4	4	23
24	Lighting Fixture Repair	2004	923		20	46	46	46	24
25	Garbage Disposal	2004	1,804		20	90	90	90	25
26	Alarm Repairs	2004	578		20	29	29	29	26
27	Elevator Repairs	2004	878		20	44	44	44	27
28	Roof Exhaust Fan	2004	2,114		20	106	106	106	28
29	Ac Repairs	2004	1,824		20	91	91	91	29
30	Ac Repairs	2004	749		20	37	37	37	30
31	Cornice Upholstery	2004	3,725		20	186	186	186	31
32	Wallcovering	2004	767		20	38	38	38	32
33	* Items Included On 6/30/04 Capital Report	2004			20				33
34	TOTAL (lines 1 thru 33)		$ 8,046,059	$ 304,670		$ 316,182	$ 11,512	$ 3,396,823	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 8,046,059	$ 304,670		$ 316,182	$ 11,512	$ 3,396,823	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,046,059	$ 304,670		$ 316,182	$ 11,512	$ 3,396,823	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 8,046,059	$ 304,670		$ 316,182	$ 11,512	$ 3,396,823	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,046,059	$ 304,670		$ 316,182	$ 11,512	$ 3,396,823	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 8,046,059	$ 304,670		$ 316,182	$ 11,512	$ 3,396,823	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,046,059	$ 304,670		$ 316,182	$ 11,512	$ 3,396,823	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 8,046,059	$ 304,670		$ 316,182	$ 11,512	$ 3,396,823	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,046,059	$ 304,670		$ 316,182	$ 11,512	$ 3,396,823	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 8,046,059	$ 304,670		$ 316,182	$ 11,512	$ 3,396,823	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,046,059	$ 304,670		$ 316,182	$ 11,512	$ 3,396,823	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
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62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$	$		$	$	$	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$	$		$	$	$	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 867,021	$ 68,360	$ 83,916	$ 15,556	10	$ 520,690	71
72	Current Year Purchases	71,594	40,689	9,697	(30,992)	10	9,697	72
73	Fully Depreciated Assets	495,232				10	495,232	73
74								74
75	TOTALS	$ 1,433,847	$ 109,049	$ 93,613	$ (15,436)		$ 1,025,619	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 9,508,366	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 413,719	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 409,795	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (3,924)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,422,442	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	LAND - 1994	$ 199,000	$	$	86
87	REMODEL STORAGE ROOM - 1999	4,000	200		87
88	REMODEL STORAGE RM - 1999	10,000	500		88
89	REMODEL STORAGE ROOM - 1999	4,300	215		89
90	DAYCARE CTR ARCHITEC - 2000	787	39		90
91	TOTALS	$ 218,087	$ 954	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 17,749 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	DODGE VAN	$ 450.00	$ 6,380	17
18	ADMINISTRATIVE		640.00	7,680	18
19					19
20					20
21	TOTAL		$ 1,090.00	$ 14,060	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 84

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$ 5,480	$	$	$ 5,480
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests	477			477
9	TOTALS	$ 5,957	$	$	$ 5,957
10	SUM OF line 9, col. 1 and 2 (e)	$ 5,957			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	9
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	9

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 150,786	$		$ 150,786	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			9,799			9,799	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			185,133			185,133	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				228,950		228,950	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental					39,887	76,733		116,620	13
14	TOTAL			$		$ 385,605	$ 305,683		$ 691,288	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center **#** 0027680 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/04 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 141,759	$	1
2	Cash-Patient Deposits	104,322		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,270,555		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	378,055		5
6	Prepaid Insurance	105,034		6
7	Other Prepaid Expenses	3,287		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	69,522		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,072,534	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	227,460		13
14	Buildings, at Historical Cost	5,384,307		14
15	Leasehold Improvements, at Historical Cost	2,468,433		15
16	Equipment, at Historical Cost	1,484,880		16
17	Accumulated Depreciation (book methods)	(4,616,110)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	31,864		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,980,834	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,053,368	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 354,632	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	116,277		28
29	Short-Term Notes Payable	1,634,398		29
30	Accrued Salaries Payable	94,457		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,125		31
32	Accrued Real Estate Taxes(Sch.IX-B)	217,000		32
33	Accrued Interest Payable	31,166		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	5,335		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,460,390	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,659,780		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,659,780	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,120,170	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,933,198	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,053,368	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,283,120	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,283,120	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(292,722)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(57,200)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (349,922)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,933,198	24	*

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,801,183	1
2	Discounts and Allowances for all Levels	97,370	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,898,553	3
	B. Ancillary Revenue		
4	Day Care	42,905	4
5	Other Care for Outpatients		5
6	Therapy	671,400	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 714,305	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	6,740	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	23,952	19
20	Radiology and X-Ray		20
21	Other Medical Services	270,791	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 301,483	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	23,629	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 23,629	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,937,970	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,148,568	31
32	Health Care	4,254,136	32
33	General Administration	1,990,545	33
	B. Capital Expense		
34	Ownership	904,476	34
	C. Ancillary Expense		
35	Special Cost Centers	786,147	35
36	Provider Participation Fee	146,820	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,230,692	40
41	**Income before Income Taxes (line 30 minus line 40)****	(292,722)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (292,722)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Not Complete **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,224	$ 80,114	$ 36.02	1
2	Assistant Director of Nursing	3,673	4,191	137,522	32.81	2
3	Registered Nurses	30,346	33,390	870,640	26.07	3
4	Licensed Practical Nurses	25,217	26,907	659,780	24.52	4
5	Nurse Aides & Orderlies	131,237	141,218	1,499,704	10.62	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,767	6,472	73,052	11.29	8
9	Activity Director					9
10	Activity Assistants	16,162	17,456	151,862	8.70	10
11	Social Service Workers	23,658	26,598	440,075	16.55	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	36,469	38,917	367,227	9.44	15
16	Dishwashers					16
17	Maintenance Workers	21,258	23,469	249,020	10.61	17
18	Housekeepers	33,138	36,151	312,460	8.64	18
19	Laundry	17,099	18,262	166,756	9.13	19
20	Administrator	2,080	2,428	115,376	47.52	20
21	Assistant Administrator	2,080	2,280	58,673	25.73	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,939	13,046	203,310	15.58	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,771	4,199	70,162	16.71	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	6,466	7,002	84,688	12.09	33
34	TOTAL (lines 1 - 33)	372,440	404,210	$ 5,540,421 *	$ 13.71	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 16,347	01-03	35
36	Medical Director	Monthly	24,018	09-03	36
37	Medical Records Consultant	Monthly	1,472	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,924	10-03	39
40	Physical Therapy Consultant	Monthly	5,415	10a-03	40
41	Occupational Therapy Consultant	Monthly	7,588	10a-03	41
42	Respiratory Therapy Consultant	Monthly	2,995	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	845	11-03	44
45	Social Service Consultant	Monthly	5,413	12-03	45
46	Other(specify)				46
47	URB Consultant	Monthly	765	10-03	47
48					48
49	TOTAL (lines 35 - 48)		$ 69,782		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Marla Benson	Administrator	0.00	$ 115,376
Ross Zeller	Asst. Admin	0.00	58,673
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 174,049

B. Administrative - Other

Description	Amount
SHA, Ltd - Management Fees	$ 155,000
ProHealth - Administrative Fees	110,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 265,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Gary Weintraub	Legal	$ 3,083
Personnel Planners	Unemployment Tax Cons	4,896
FRR	Accounting	51,989
Paychex	Data Processing	13,733
Bisys	Data Processing	300
AccuMed	Computer Services	4,000
Medicare Data Systems	Computer Services	494
SLS	Computer Services	5,928
KIPP Computer	Computer Services	325
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 84,748

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 151,418
Unemployment Compensation Insurance	48,698
FICA Taxes	410,893
Employee Health Insurance	163,439
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits	12,124
TOTAL (agree to Schedule V, line 22, col.8)	$ 786,572

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	20,536
Health Care Worker Background Check	2,576
(Indicate # of checks performed 161)	
Licenses and Fees	9,328
Dues ICLTC	10,493
Dues and Subscriptions	103
Advertising and Promotion	34,759
Less: Public Relations Expense	( )
Non-allowable advertising	(34,759)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 44,031

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	9,254
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,254

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC - $10493**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **9,775** Line **10-02**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **146,820**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln 14**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.